Indiana PERF
Public Employees' Retirement Fund

APPLICATION FOR SURVIVOR BENEFITS
1977 POLICE OFFICERS' & FIREFIGHTERS' PENSION & DISABILITY FUND

State Form 7045 (R2 / 8-08)

1977 POLICE OFFICERS' & FIREFIGHTERS' PENSION & DISABILITY FUND
143 West Market Street
Indianapolis, Indiana 46204-2899
Toll Free: 1-888-526-1687

* This agency is requesting disclosure of Social Security Numbers in accordance with IRS code; disclosure is mandatory and this form will not be processed without it.

INSTRUCTIONS:

1. *Please type or print.*
2. *Please submit a copy of the deceased member's birth certificate and copies of the birth certificates of all survivors. Documents showing the date of birth may be a photocopy of a birth certificate, a baptismal or confirmation certificate, or a court decree. Attach an English translation to any foreign document.*
3. *Please submit a copy of the member's death certificate.*
4. *Please submit a copy of the marriage certificate.*
5. *Please have this application notarized.*
6. *All of the above items must be provided; this application will not be processed without them.*

SECTION 1 - DECEASED MEMBER INFORMATION

Name of deceased member (*first, middle, last*)		Social Security Number *
Legal address at time of death (*number and street, city, state, and ZIP code*)		
Date of birth (*month, day, year*)	Date of death (*month, day, year*)	Last date of employment (*month, day, year*)

SECTION 2 - SURVIVOR INFORMATION

The Police Officers' and Firefighters' Pension and Disability Fund provides for survivor benefits. A survivor, as defined by Public Law 9 (Special Session) of 1977, is each surviving child under the attained age of eighteen (18), unless disabled; the surviving spouse; or if there is no surviving child or spouse, the surviving parent or parents, if wholly dependent on the member. Please give the below information for each beneficiary who is to receive any possible benefit that is payable by the Fund. If additional space is needed, please attach a separate sheet.

Name (*first, middle, last*)		Relation to member
Address (*number and street, city, state, and ZIP code*)		
Telephone number ( )	Date of birth (*month, day, year*)	Social Security Number *
Name (*first, middle, last*)		Relation to member
Address (*number and street, city, state, and ZIP code*)		
Telephone number ( )	Date of birth (*month, day, year*)	Social Security Number *
Name (*first, middle, last*)		Relation to member
Address (*number and street, city, state, and ZIP code*)		
Telephone number ( )	Date of birth (*month, day, year*)	Social Security Number *

SECTION 3 - AFFIDAVIT - MARRIED AT TIME OF DEATH

I hereby affirm that I was married to _____, Social Security Number _____,
Name of member

at the time of his/her death on _____.
Date (month, day, year)

Signature	Printed name	Date (*month, day, year*)

I hereby apply for survivor benefits under the supplemental benefit of Public Law 9 (Special Session) of 1977.

In accordance with the requirements of the 1977 Police Officers' and Firefighters Pension and Disability Fund of Indiana, I hereby make the above declarations, which are true to the best of my information, knowledge, and belief. These declarations are to constitute warranties affecting the granting of survivor benefit by the said Fund.

I hereby depose and say that: I am the person who made the foregoing statements; I have carefully read the questions and the answers thereto and understand the same; each and every one of such answers is full, complete and true, and no material fact has been concealed or omitted therefrom; and that said answers are made for presentation to the board of trustees of the 1977 Police Officers' and Firefighters' Pension and Disability Fund in making claim for a survivor benefit that may be payable to me under Public Law 9 (Special Session) of 1977.

Signature of survivor	Printed name	Date (*month, day, year*)

CERTIFICATION OF NOTARY PUBLIC

STATE OF _____

SS:

COUNTY OF _____

The above information was subscribed and sworn to before me, a notary public, in and for the state and county above named, by the applicant, who is to me personally known, on this _____ day of _____, 20_____.

Signature of notary public	Printed name of notary public
County of residence	Date commission expires (*month, day, year*)

CERTIFICATION OF EMPLOYER

Complete only if member was active / working at the time of death.

I hereby certify that the last day of work for _____, was _____.
Name of member *Date (month, day, year)*

Signature of controller / clerk treasurer	City or town	Date (*month, day, year*)

Please indicate, where appropriate, any employee contributions or employer-paid employee mandatory contributions which have been deducted from pay and are either on a quarterly report in transit or will be reported in the future. Do not accumulate figures. Show amounts only by quarter for each quarter still to be reported. Please always indicate this information for the quarter that includes the last day in pay status. No estimates can be accepted.

Quarter	Wages Paid	Contribution

I hereby certify the above information for _____.
Name of employee

Signature of city controller / clerk treasurer / trustee	Title	Date (*month, day, year*)